

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

ORIGINAL

PRINTED: 03/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/20/2015
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NAME OF PROVIDER OR SUPPLIER AVERA MARYHOUSE LONG TERM CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 717 EAST DAKOTA PIERRE, SD 57501
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000 INITIAL COMMENTS

Surveyor: 27473
A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/19/15 through 2/20/15. Areas surveyed included resident assessment, safety, and state reporting. Avera Maryhouse Long Term Care was found not in compliance with the following requirements: F309 and F323.

F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING
SS=G

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Surveyor: 30170
Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (1) who had eloped through his third story window in his room, was found outside the facility lying on the ground, was taken to the hospital by ambulance, and later died from his injuries had the appropriate:
*Safety measures in place to prevent the elopement.
*Monitoring of his anti-psychotic medication.
*Social services consultation.
Findings include:

F 000

Addendums noted with an asterisk per 3/17/15 telephone to facility DON. DW/SDDCH/MF

F 309

The corrective action includes safety measures in place to prevent elopement. Elopement Policy 6312-60 has been reviewed and revised to indicate that the facility will use the elopement risk assessment in the facility's documentation system, upon admission, quarterly, with any newly identified elopement risk behaviors, and with significant changes.

If elopement risk is newly identified, Social Services will be contacted. For those residents deemed at risk for elopement through the facility elopement risk assessment, the interdisciplinary team will complete an additional elopement risk assessment which is scored for degree of risk.

**3/19/15
DW/SDDCH/MF*

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Handwritten Signature]

TITLE

Administrator

(X6) DATE

RECEIVED
DATE: 03/03/2015
SD DOH & C

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 45 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 309	<p>Continued From page 1</p> <p>1. Review of resident 1's medical record revealed he had:</p> <ul style="list-style-type: none"> *Been admitted on 12/16/14 and was sixty-six years old. *A cardiac arrest on 10/5/14. *A long standing history of alcoholism and (a phychiatric disorder that can take a person away from reality at times) lived alone with his dog. *Depression, anxiety, schizophrenia, dementia, cognitive (memory) disorder, heart failure, hypertension (high blood pressure), cardiomyopathy (an enlarged heart). *Been prescribed the anti-psychotic medication (med) Latuda 80 milligrams (MG) daily, and was admitted with that med. *Fallen at home and fractured his right ankle. *Jumped from the third story window of his room to the ground below on 2/13/15, was taken to the emergency room, and died on 2/13/15. <p>Observation on 2/19/15 at 4:00 p.m. of resident 1's room on third floor revealed:</p> <ul style="list-style-type: none"> *There was a large cut in the window screen, approximately one and one-half feet in length and almost the whole length of the window on the right side of the screen. *There was an ink pen lying on the window sill. *There were a large silver nail clippers and a pink straight-edge razor lying on the top of his dresser. *There were two nails approximately one and one-half inches long that were placed in a blue material by the heating and cooling register. *The black mechanism to lock the window was broken. <p>Interview on 2/19/15 at 4:15 p.m. with the director of nursing (DON) regarding resident 1 revealed:</p> <ul style="list-style-type: none"> *She stated she was unsure as to how the screen had been cut. 	F 309	<p>This has been obtained from the <i>Risk Management Handbook for Healthcare Organizations, Fifth Edition, Resident Rights Self Assessment Compliance Handbook.</i></p> <p>This will produce a score. Residents scoring 10 or more will be considered at high risk for elopement. The guidelines for best practices that accompanies this tool will be considered when developing individual care plan approaches.</p> <p>Two of these guidelines include 1 to 1 supervision and physician notification to evaluate and determine the necessity of finding a more suitable facility for the resident. Care plans will have individualized interventions to reduce the risk of elopement.</p> <p>Safety Policy 6312-50 has been reviewed and revised to include the following:</p>		

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F 309	<p>Continued From page 2</p> <p>*A certified nursing assistant (CNA) working on the second floor that evening had heard a cry for "Help", the CNA then notified the nurse on the second floor. The CNA and the nurse both verified they had heard a cry for "Help." They both went outside and discovered resident 1 lying on the ground.</p> <p>*When the resident was wheelchair bound after his surgery to fix his right ankle fracture he had not tried to leave the facility.</p> <p>*After he had become mobile and walking around that was when the resident had attempted to leave and made it clear to staff "He wanted out."</p> <p>Interview per telephone on 2/19/15 at 6:30 p.m. with registered nurse (RN) B regarding resident 1 revealed:</p> <p>*She only worked part-time as an RN. She usually worked four hours a week.</p> <p>*On 2/13/15 she was working the 6:00 p.m. to 10:00 p.m. shift on second floor.</p> <p>*She heard yelling for help as she was setting at the nurses station at approximately 8:00 p.m. or maybe a little later. She thought she was hearing things, so she went to get CNA C to confirm the yelling for help.</p> <p>*She and CNA C went outside and found resident 1 lying on the ground. His legs were in front of him, his arms were underneath him, and he was half-way setting up. He was talking and alert.</p> <p>*RN B asked the resident what he had been doing, and the resident stated "I am leaving, no one would let me leave."</p> <p>*The resident told her he had jumped from his window.</p> <p>*She was aware the resident's window had been screwed shut to prevent the resident from opening the window. That information had been discussed in nursing report. Staff were concerned</p>	F 309	<p><i>"Upon admission residents are assessed for various risk factors including but not limited to falls, elopement, skin break-down, cognitive impairment, and depression. Safety checks at specified intervals or 1 to1 supervision may be indicated for some residents at particular risk. This will be care planned for the individual by the care plan team."</i></p> <p>Safety checks will be documented in the resident's record.</p> <p>The following is another change made to Safety Policy 6312-50.</p> <p><i>"For safety of residents, window stops are present in the residential wings throughout the facility."</i></p> <p>Plant Operations will have installed these window stops in all windows that are capable of being opened in the residential wings of the facility by March 19, 2015.</p>	

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F 309	<p>Continued From page 3</p> <p>about him opening the window. *Resident 1 always wanted to leave and go home. He had a plastic bag full of his clothes and an envelope of money with him when she and CNA C found him lying outside. *She had been contacted by the DON earlier in the week to come to the facility and thoroughly document the incident on 2/13/15. She had completed that documentation on 2/19/15.</p> <p>Interview on 2/20/15 at 8:25 a.m. with maintenance man G regarding the window in resident 1's room revealed: *He had been asked by social service designee F to place the screw in the window to prevent the window from being opened approximately two or three weeks ago. *The screw was a one inch screw with a Phillips head, and he had placed it directly into the metal window frame. The screw was missing after resident 1 had jumped out the window on 2/13/15. He thought the screw had been sticking out approximately a quarter of an inch.</p> <p>Interview on 2/20/15 at 8:40 a.m. with social service designee F regarding resident 1 revealed: *She wanted the resident to be safe. *She had not instructed the staff about the screw placed in the metal frame of his window. *He had been secluded to the third floor after the 2/6/15 incident where he had eloped outside, had become agitated, and had hit staff. He was then taken to jail. *She stated the staff were instructed they had to take resident 1 back after he had gone to jail on 2/6/15. *She had not contacted social service consultant L in regards to her concerns. *She had retrieved the screw that had been</p>	F 309	<p>Monitoring of the behaviors and potential side effects for those residents receiving anti-psychotic medications will be addressed in Pyschopharmacological Medication Policy 6312-51 which has been reviewed and revised to include the following:</p> <p><i>"Direct care staff are required to monitor and document the mood and behaviors of any resident prescribed antipsychotics. The interdisciplinary team determines the frequency with which this documentation is required, based upon the individual resident's medications, their behaviors, and other risk factors. The licensed nurse will document effectiveness of the medication and any noted adverse effects. The physician will be notified immediately of any adverse effects."</i></p> <p>As of March 14, 2015, direct care staff have monitored and documented mood and behavior for all residents currently prescribed antipsychotics.</p>		

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F 309	<p>Continued From page 4</p> <p>placed in his window. The screw had been found lying in the window sill in the window tract after he had jumped out the window on 2/13/15.</p> <p>*Resident 1 wanted to leave the facility; he had made that very clear to staff.</p> <p>*There had been no consistent resident safety checks on resident 1. He had been checked by staff at meal times and during medication administration.</p> <p>*She agreed he had been a high risk for elopement.</p> <p>Review of an e-mail on 1/27/15 at 1741 (5:41 p.m.) regarding resident 1 revealed "When this nurse reported for duty, resident had been to Lutheran services then to activities. He requested pain med for leg and refused to go to 3rd floor. Norco [pain med] was given to him @ [at] 1630 [4:30 p.m.] for lower, leg pain. He had gone to Mass then was escorted to supper. One on one watch at all times while off 3rd floor. The plan is that after he returns to 3rd floor he will not be allowed to go to meals or activities off 3rd floor until he is evaluated on Tuesday 2/3. The window to his room has been adjusted so that it may only be opened a short distance."</p> <p>Review of resident 1's 12/16/14 Elopement Risk Assessment revealed:</p> <p>*He was cognitively impaired with poor decision making skills.</p> <p>*He had possible schizophrenia with a history of alcoholism.</p> <p>*He could independently get around in his wheelchair.</p> <p>*He did not want to be at the facility and wanted to go home.</p> <p>*No new behaviors were noted.</p> <p>*All family members were concerned he would</p>	F 309	<p>To address utilizing Social Service Consultation when working with a multi-complex or challenging individual, two policies have been reviewed and revised. Elopement Policy 6312-60 now reads:</p> <p><i>"At the time elopement risk is newly identified, the licensed nurse will contact social services and will implement a WanderGuard bracelet as appropriate per assessment. The on-call social worker should be notified after hours and on weekends. Multi-complex and challenging residents will be referred to the social services supervisor for consultation."</i></p> <p>Psychopharmacological Medications Policy 6312-51 has been reviewed and revised under the care planning section to include:</p> <p><i>"Multi-complex or challenging residents will be referred to the social services supervisor for consultation."</i></p>	

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F 309	<p>Continued From page 5 leave the facility. *He had a history of leaving against medical advice from the emergency room (ER) not waiting for them to discharge him. *He had a Wanderguard (an alarm system that would sound when he came close to an exit door) on his wheelchair.</p> <p>Review of resident 1's 1/28/15 Elopement Risk Assessment revealed: *He was now ambulating independently. *He had a history of leaving the facility and not telling the staff. *He had expressed a desire to leave and go home, had packed his belongs, and had stayed near exits. He had wanted to "get out of here" constantly. *Staff were very concerned about his leaving without anyone realizing he was gone. *"Incident yesterday 1/27/15 where he went out the back door of [name of the restaurant] while using the bathroom, was there accompanied by [a social worker from an outside agency] who were there supervising him; police was contacted, he was found inside a bank within walking distance of the [restaurant name], and they returned to the [facility name]; [facility name] staff were asked by his guardian to come out and talk him into returning to facility; he eventually did, and [facility name] adjusted the plan of care to keeping his on 3rd floor through the next 7 days because of his very high elopement risk."</p> <p>Review of resident 1's 2/12/15 (one day before he eloped and jumped from the third story window) Elopement Risk Assessment revealed: *He was cognitively impaired with poor decision making skills. *He had schizophrenia and was a vulnerable</p>	F 309	<p>Education will be provided for all facility staff to include the revision of policies Safety 6312-50; Psychopharmacological Medications 6312-51, & Elopement 6312-60 listed above by March 19, 2015.</p> <p>A monitor for compliance in identifying elopement risk upon admission, quarterly, newly identified elopement risk behaviors, and with significant changes, along with the use of the scored elopement risk assessment tool, will be completed by the MDS Coordinator who will complete two monitors weekly.</p> <p>The results of the monitors and any identified concerns will be reviewed monthly by the Administrator and Director of Nursing (DON). The DON will report to the Quality Improvement Committee (QIC) in May, 2015. This will be continued quarterly until the QIC advises to discontinue.</p> <p><i>* or sooner as needed DWK/DDO/HMF</i></p>	

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F 309	<p>Continued From page 6 adult. *He was ambulating independently. *He had continued to express a desire to go home, had packed his belongs and stayed by exit doors. *There were no new behaviors were noted. *His guardian K had expressed elopement concerns. *He was at risk for elopement. *He was to remain on third floor per guardian K's request.</p> <p>Review of resident 1's 12/20/14 Mood and Behavior sheet typed in all capital letters revealed "RESIDENT STATES HE DOES NOT KNOW WHY HE WAS PUT HERE, HE DOES NOT BELONG IN A NURSING HOME, HE DOES NOT LIKE TO BE ASKED QUESTIONS, HE DOES LIKE PEOPLE TELLING HIM WHAT TO DO. YELLING AND UPSET". *The intervention was to "leave" the resident safe.</p> <p>Review of resident 1's 12/28/14 Mood and Behavior sheet revealed "saying he does not want to be here refusing to eat, he said he is not hungry when he is this lonely." *The interventions were: -One on one staff. -Give food. -Give fluids. -Back rub. -Leave resident safe. -Come back later.</p> <p>Review of resident 1's 1/19/15 Mood and Behavior sheet revealed "I will do whatever it takes to get out of here, and I will hurt someone to get out of here, I am going to kill myself." He stated to social worker [F] "If I had aids and</p>	F 309	<p>A monitor for compliance with safety measures for individuals and groups as a whole includes checking that window stops are in place, will be completed by Plant Operations personnel. Ten windows will be checked weekly in varied locations throughout the residential wings of the facility. The results of the monitors and any identified concerns will be reviewed monthly by the Administrator and Director of Plant Operations (DPO). The DPO will report to the QIC in May, 2015. This will be continued quarterly until the QIC advises to discontinue.</p> <p>A monitor for compliance with mood and behaviors for antipsychotic medications will be completed weekly by the Social Service Associate (SSA) on two residents who are taking antipsychotic medications.</p> <p><i>* or sooner as needed DW/ROD/HMF</i></p>		

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F 309	<p>Continued From page 7</p> <p>contaminated people would I be able to leave? If I smoke in my room will you kick me out of if I drink in my room will you kick me out?" The resident followed the nurse to several rooms while this nurse was giving pills and kept saying over and over how he hates it here and he is treated like a prisoner and wants to be able to leave. This nurse told him that is something he needs to take up with his guardian [name of the guardian] and [name of the counseling service]." *There were no interventions documented.</p> <p>Review of resident 1's 2/9/15 Mood and Behavior sheet revealed: **While giving [resident's name] his morning medications [resident name] stated, "I am sad about being here, I need to get out, I would rather be in jail. I am going to get a power of attorney so I can get out of here". He was also asking what he could do to get kicked out of the facility. *The interventions were one on one, give fluids, TV, and come back later.</p> <p>Review of an e-mail from social services from a call from the provider's DON on 2/18/15 at 8:28 a.m. but documented as a late entry for, 1/29/15 revealed: *The DON kept reiterating that (name of the resident 1) did not want to be at (name of the facility). *The DON had felt the provider could not meet his need because the unit was not secure. **[DON name] stated she was not comfortable with this situation, and I [social service person] suggested they may need to make adjustments to make sure [name of the resident] remained safe and somewhat content while he was there, like having the activities director come up to see him since he couldn't leave the floor."</p>	F 309	<p>A monitor for side effect tracking and effectiveness of psychopharmacological medications will be completed weekly by the SSA for five residents taking any psychopharmacological medication.</p> <p>The results, and any identified concerns, of both these monitors completed by SSA, will be reviewed monthly by the Administrator and the DON. The DON will report to the QIC in May, 2015. These will be continued quarterly until the QIC advises to discontinue.</p> <p><i>* or sooner as needed DWKSDCHIME</i></p>	

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F 309	<p>Continued From page 9</p> <p>hospitalization for his fractured ankle.</p> <p>*He had been falling at home, and it was felt that he needed extra assistance.</p> <p>*He was adamant about going home. He had been refusing to go to a long term care facility for further assistance after his surgery.</p> <p>*He had been taken to another long term care facility for admission, but when he had gotten to the facility there were no physician's orders and they had refused to take him. He then was returned to his home town, admitted to the hospital under observation status, and was admitted to the current provider for care.</p> <p>*She met weekly with social service designee F.</p> <p>*Social service designee F had never mentioned any concerns regarding resident 1.</p> <p>Interview per telephone on 2/20/15 at 11:00 a.m. with social service guardian K regarding resident 1 revealed:</p> <p>*He had made a comment on 2/10/15 at 1:30 p.m. during their conversation he was thinking of doing something.</p> <p>*Restrictions had been put in place to confine him to the third floor, because he was an elopement risk. He wanted to go home.</p> <p>*She had spoken to the charge nurse that evening to convey the above information regarding resident 1.</p> <p>Interview per telephone on 2/20/15 at 11:30 a.m. with licensed practical nurse E regarding the phone call from resident 1's guardian K above revealed:</p> <p>*Guardian K had called and stated he was not to leave the third floor.</p> <p>*He had told her he would rather be in jail, and he did not belong here.</p> <p>*She felt he was scheming to leave the facility.</p>	F 309	<p>A monitor for compliance for the Social Service Associate to consult with their Social Service Supervisor, when working with a multi-complex or challenging individual, will be completed by the MDS Coordinator who will complete two monitors weekly. The results of the monitors and any identified concerns, will be reviewed by the Administrator and the DON. The DON will report to the QIC in May, 2015. This will be continued quarterly until the QIC advises to discontinue.</p> <p><i>* monthly or sooner as needed DN/KDDCH/MF</i></p>	

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F 309	<p>Continued From page 10</p> <p>*No one thought he would ever go out the window.</p> <p>*She was told by the guardian he was not allowed off the third floor, and was not allowed to have visitors.</p> <p>Review of resident 1's social service documentation from his guardianship revealed on 2/20/15 at 1:30 p.m. "During conversation (resident's name) did mention he was "thinking of doing something." But he would not tell what that plan was. He had mentioned earlier he would leave the facility.</p> <p>Review of resident 1's Phych Medication Tracking (would track any adverse reactions or side effects of the medication Latuda) documentation from 12/19/15 through 2/3/15 revealed: *There was no documentation on 12/26/15. There was documentation on 12/29/15. *There was no documentation from 1/9/15 through 1/24/15. *There was no documentation from 2/3/15 through 2/13/15.</p> <p>Review of resident 1's 12/16/14 comprehensive care plan revealed: *He was an elopement risk. *He was on resident safety checks. *On 2/3/15 "He can go down to meals and or activities if staff is available to stay with him at all times. If staff has to leave the area he is in and another staff cannot take over (resident's name) will need to return to 3rd floor. If (resident's name) makes comments about leaving or gives the staff a difficult time about going back up to 3rd floor it may affect later opportunities he may have to go downstairs." *On 1/27/15 Problem: "(residents name) is</p>	F 309			

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F 309	<p>Continued From page 11</p> <p>classified as a vulnerable adult and has a court appointed guardian. He has instructions to remain at (facility name) and participate in skilled therapy until his ankle is fully healed, but he has limited judgement, and limited understanding of his need to reside in the facility until his ankle is fully healed, and a strong desire to go home."</p> <p>*The Goal: " (resident's name) will remain safely in the facility until right ankle is healed."</p> <p>*Approaches: "(resident's name) has a room on third floor with a Wandergard on his walker. (resident's name) is to remain on the 3rd floor for meals and activities until Tuesday, February 3, 2015. On February 3, 2015 he can resume meals and activities off third floor with staff supervision. Monitor his whereabouts with all opportunities." *On 2/7/15 "he must stay on the floor at all times."</p> <p>Review of resident 1's 12/22/14 Minimum Data Set (MDS) assessment revealed: *He scored a fifteen with cognition (memory) which meant he was alert and orientated to person, place, and time. *He had no physical or verbal behaviors . *He had no wandering tendencies *It was very important to him to be around his pet. *It was very important to him to participate in religious services or practices.</p> <p>Review of resident 1's 2/9/15 MDS revealed: *He was cognitive (memory) impaired. He had a score of ten out of fifteen. *He was feeling down, depressed, and hopeless. *He was not classified as a wandering resident. *He was independent with locomotion on the unit with supervision. *He required supervision off the unit. *He had not had any signs of psychosis (very abnormal behaviors such as hallucinations).</p>	F 309		

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F 309	<p>Continued From page 12</p> <p>*He had some physical and verbal behaviors noted.</p> <p>Review of his 2/9/15 Care Area Assessment revealed: *His BIMS (brief interview for memory status) was 10. A score of 15 would mean orientated to person, place, and time. *He had gone to jail due to hitting a staff person after trying to leave the building. *He was always verbalizing his desire to leave. *He was not feeling bad about himself, but he just wanted to leave the nursing home.</p> <p>Review of resident 1's nursing notes from 2/10/15 through 2/13/15 revealed: *On 2/10/15 at 1442 (2:42 p.m.) "Call from [guardians name], asked us not to allow [resident's name] to attend Mass this eve. [evening] at 4:00 p.m. After thinking about her visit with him earlier today, she feels he is scheming. Relayed this to eve. nurse, and asked [name of office person] in office to give the message to the DON." *On 2/11/15 at 1753 (5:53 p.m.) "[resident's name] is requesting someone to help him fill out application for [name of legal service] as he wants an attorney to help him to regain his own guardianship so he can leave [the name of the facility]." *On 2/12/15 at 1054 (10:54 a.m.) No problems were noted. *There was no documentation until 2/13/15 at 2202 [10:02 p.m.] "At approximately 20:30 [8:30 p.m.] as I was charting in the 2nd floor nurses station, and I heard someone yelling, "help me." After looking on our floor and not finding anyone awake and hollering I sat back down, I then heard "help me." At the time [certified nursing</p>	F 309			

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F 309	<p>Continued From page 13</p> <p>assistant's name] open the screened porch door where I saw resident laying in the grass yelling "help me." At that time I called for third floor nurse to meet me outside. Upon assessment [nurse's name] call 911 and the DON."</p> <p>"Then there were late entries made after the resident's death as follows:</p> <p>-On 2/17/15 (four days after his death) "On Friday Feb. [February] 13 at 1930 [7:30 p.m.] resident caught me and asked me for his medication. He stated he wanted to go to bed early. At 2030 [8:30 p.m.] 2nd floor nurse calls and says that resident is outside. Ran to front door and outside and did not see staff or resident. 2nd floor nurse calls me to lawn at the lower west side of the building. Note that resident is lying on the ground. He is talking. He said he thinks he broke his leg. We tell him to be still and that we are going to call the ambulance. Area was dark and not able to see what or how he was injured. Called 911 at 2048 [8:48 p.m.]. Notified DON at 2050 [8:50 p.m.] Police here and he lifted resident's pant leg and bleeding noted to leg that he had previously injured. Police wanted to see resident's room. Took him to room _____ and noted the window to the outside was open and the screen had been torn. Noted that resident may have pulled himself to the area on lawn from below his window to area close to the old patio exit door that is now boarded up. Resident then taken to the ER [emergency room] via ambulance. Sent contact info [information] and order with ambulance crew. ER had contacted us about code status. Was able to tell them that he was a full code. [Name] spiritual care stopped by to let us know that this resident had passed away prior to 2300 [11:00 p.m.] in the ER."</p> <p>Review of the provider's 11/5/12 Elopement</p>	F 309		

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F 309	<p>Continued From page 14 (Patient/Resident) policy revealed: *The purpose was to prevent patient/resident injury due to elopement, and to report/investigate all incidents of missing patients/residents. *It was the responsibility of all personnel to prevent patient/resident elopement.</p> <p>Review of the provider's January 2015 Psychopharmacological Medications policy revealed: *The purpose of the policy was to promote quality of life and optimization of functional abilities for residents who demonstrated mood and behavior disturbances. *When antipsychotic medications were being used to treat enduring conditions, targeted behaviors must be clearly documented before increasing or implementing new medications. Monitoring must ensure behavioral symptoms were not due to medical conditions, or problems, environmental stressors, or psychological stressors that could be addressed or resolved without medication adjustments. *There must be documentation in the medical record demonstrating the condition persisted and that other approaches had been attempted and failed to adequately address the symptoms. Direct care staff would document effectiveness of the medication and any noted adverse effects using the Psych Medication Tracking intervention with Meditech.</p> <p>Review of the provider's undated Social Service Designee job description revealed: *The full time position provided social work services to the residents in order to meet the resident's psychosocial needs. *The position was to provide crisis interventions, and provide individual and group psychosocial</p>	F 309		
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F 309	<p>Continued From page 15 programs.</p> <p>*The social service designee was to:</p> <ul style="list-style-type: none"> -Follow through and follow-up. -Anticipate and respond to individual's needs. -Anticipate and correct problems before they became complaints. -Were innovative, and find solutions. -Collaborated with others to deliver the highest quality of care or services. -Encouraged correspondence, visits, and telephone calls from families. -Provided support to the resident. <p>Review of the provider's undated Director of Nursing Service job description revealed:</p> <p>*That position was responsible for assessing, planning, directing, coordinating, and evaluating services and activities.</p> <p>*The director of nursing was to:</p> <ul style="list-style-type: none"> -Follow through and follow-up. -Anticipate and respond to individual's needs. -Anticipate and correct problems before they became complaints. -Own each situation. -Was innovative, and found solutions. -Collaborated with others to deliver the highest quality care or service. <p>Review of the provider's undated Registered Nurse (RN/Charge Nurse) job description revealed:</p> <ul style="list-style-type: none"> *Consistently and thoroughly completed documentation in a timely manner. *Required knowledgeable status and needs of the residents and communicated effectively with team members. <p>Review of the provider's February 2015 Nursing Documentation policy revealed:</p>	F 309			

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F 309	<p>Continued From page 16</p> <p>*The purpose of the policy was to have established a system of documentation compliant with long term care regulations and to ensure continuity and delivery of safe, quality healthcare to each resident.</p> <p>*When there were any new complaint or a change in condition the nurse would perform an assessment and document the finding in the resident's medical record.</p> <p>*Documentation should have been completed as soon as possible, and before the end of the shift.</p> <p>Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8 th Ed., St. Louis, Mo., 2013, p. 23 and pp. 369 through 371 revealed:</p> <p>*Safety is a critical part of quality health care.</p> <p>*Cognitive impairment associated with delirium, dementia, and depression place patients at greater risk for injury.</p> <p>*Patient safety continues to be one of the most pressing health care challenges in the nation.</p> <p>*Specific risks to a patient's safety within the health care environment include falls, patient-inherent accidents, procedure-related accidents, and equipment-related accidents. The nurse assesses for these four potential problems areas and, considering the developmental level of the patient, takes steps to prevent or minimize accidents.</p> <p>*Successful critical thinking requires a synthesis of knowledge, experience, information gathered from patients, critical thinking attitudes, and intellectual and professional standards. Clinical judgements require the nurse to anticipate necessary information, analyze the data, and make decision regarding patient care. Critical thinking is an ongoing process.</p> <p>*In the case of safety, the nurse integrates</p>	F 309			

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F 323	<p>Continued From page 18</p> <p>"At approximately 20:30 [8:30 p.m.] on 2-13-15 [name of resident 1] was found out on the grass yelling for help. He had slit the window screen in his room and jumped out the window. 911 was called; police and guardian. [resident's name] was taken by ambulance to the ER [emergency room]. [Facility name] rec'd a call from our hospital that [resident's name] had passed away. DSS is [resident]'s guardian."</p> <p>Observation on 2/19/15 at 4:00 p.m. of resident 1's room on the third floor revealed:</p> <ul style="list-style-type: none"> *The door had been closed, and no one was to enter until further notice per a posted sign. *The double window took up much of the exterior wall of the room. -The locking mechanism of the window was broke. -The window screen was torn away on the right side with varied jagged-like edges, and appeared like it had been cut. It was approximately 18 inches in length and almost the whole length of the screen. -There was an empty screw hole in the window sill approximately 4 to 6 inches from the side of the window. -On the window sill there were two stacks of magazines, two half and half creamers, half a ham sandwich, LED star light, angel globe, phone directory open to the City, County, State, and U.S. Government offices page, and an ink pen. *There was a wall register in front of the window. -The register was still putting out heat. -On top of the register there was a stack of mail, box of tissues, and the TV controller. -Toward the bottom of the register there was what appeared to be a filter running the length of the register with a blue sponge like material on each side with an approximate one and one-half inch 	F 323		

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F 323	<p>Continued From page 19 nail through it.</p> <p>*There was a nightstand with assorted items to the right of the window as well as a tray table and walker.</p> <p>*There was a folding chair positioned between the night stand and the window sill.</p> <p>*There was a large recliner to the left of the window.</p> <p>*There was a pink straight-edge disposable razor and a large silver nail clipper lying on top of the dresser.</p> <p>Interview on 2/19/15 at 4:15 p.m. with the director of nurses (DON) regarding resident 1 revealed: *She was unaware how the window screen had been cut.</p> <p>*She understood the certified nurse assistant (CNA) and registered nurse (RN) working on second floor had heard someone calling for help. Their search had led them to discover the resident outdoors lying on the ground.</p> <p>*The resident was not identified as an elopement risk when he had been admitted on 12/16/14; he had been wheelchair bound following surgery for a fractured ankle. He did not want to be in the building but could not leave on his own.</p> <p>*Once he became mobile and able to be up walking around, he made it clear to everyone he did not want to be in the building "He wanted out."</p> <p>Review of the floor assignment form for 2/13/15 revealed RN A, RN B, CNA C, CNA D, and CNA I had worked with resident 1 that evening.</p> <p>Interview on 2/19/15 at 4:45 p.m. with RN A regarding resident 1 revealed: *She worked on all the floors as the facility needed her to, so she did not work on third floor everytime she was scheduled.</p>	F 323			

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F 323	<p>Continued From page 20</p> <p>*He had never been aggressive or violent toward her, but she had heard he could be aggressive. She recalled she had heard he had struck out and hit a CNA.</p> <p>*On the evening of 2/13/15 she had brought in her puppy, that he had enjoyed.</p> <p>-He was in a good mood when she returned from taking the puppy home.</p> <p>-He had indicated he had talked to a lawyer, and they would not take him.</p> <p>-He talked like usual that he was "in jail here."</p> <p>-He had asked for his medications early around 7:30 p.m.</p> <p>*Later after 8:00 p.m. on the evening of 2/13/15 she heard RN B "on the walkie" telling her to come outside near the "old exit door."</p> <p>*When she arrived outside she saw RN B and CNA C with him.</p> <p>-He was lying on the ground a "good distance" from the window.</p> <p>-His brace was still on his right foot, there was blood above it when we pulled up his pant leg.</p> <p>-He had a bag of clothes near him. The other bag was below the window.</p> <p>-We called 911, the DON, and tried to get his guardian.</p> <p>-Received orders to send him to the emergency room (ER).</p> <p>*After resident 1 left by ambulance she took the police officer up to his room to look at everything. His billfold was lying on the window sill.</p> <p>*They were notified later that night he had died in the ER.</p> <p>Interview on 2/19/15 at 5:05 p.m. with licensed practical nurse (LPN) E regarding resident 1 revealed:</p> <p>*She was a traveling nurse who had been coming to the facility for a few months and was familiar</p>	F 323			

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F 323	<p>Continued From page 21</p> <p>with him.</p> <p>*She knew he had memory problems "He had no recall ten minutes later after discussion about something."</p> <p>*In the period of time she had been assigned to third floor and providing care to him she had only been able to complete two skin assessments on him. "He would tell you later, forget and then not allow me to assess him."</p> <p>*She identified him as "a person who loved dogs and enjoyed talking about them." "He was a prayful person and asked the priest to visit when he wasn't able to go to chapel."</p> <p>*She felt he "didn't fit in here, he missed his dog, he felt he was in a cage here, and just wanted to go home."</p> <p>*He had asked for help finding a lawyer, she had given him the yellow pages, and had written down a number for him. She had been told not to assist him with his request to find a lawyer.</p> <p>*His activity participation or involvement "was up to his guardian."</p> <p>*She was aware there was a screw placed in his window, so it could not be opened wide.</p> <p>*He was very mobile, and able to get around well with his walker.</p> <p>In a continued phone interview on 2/20/15 at 11:30 a.m. with LPN E about a phone call from resident 1's guardian on 2/10/15 she revealed:</p> <p>*Guardian K had called and stated he was not to leave the third floor.</p> <p>*He had told her he would rather be in jail, and he did not belong here.</p> <p>*She had felt he was scheming to leave the facility.</p> <p>*She was told by Guardian K he was not allowed off the third floor and was not allowed to have visitors.</p>	F 323			

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F 323	<p>Continued From page 22</p> <p>*No one had thought he would ever go out the window.</p> <p>Interview on 2/19/15 at 5:30 p.m. with CNA D regarding resident 1 revealed:</p> <p>*At times he was "crabby and would yell at people." He "did not want to be here. Everybody knew it."</p> <p>*They (her and other staff) were supposed to play games with him or give him magazines to look at. She knew he did "play cards sometimes."</p> <p>*He sat in a chair in the lounge a lot. "Watched TV."</p> <p>*On the evening of 2/13/15, she recalled, "it was strange, he went to bed early." "He usually went to bed at 10:00 p.m. or later."</p> <p>*When she responded to the call from second floor they had found him outside, he was on the ground.</p> <p>-He was trying to get up, he "was part sitting up and part laying down."</p> <p>-He had a bag beside him, his glasses were found in the grass away from him. There was another bag under the window.</p> <p>Review of resident 1's 12/16/14 Elopement Risk Assessment revealed:</p> <p>*He had cognitive (mental/memory, judgment and reasoning processes) impairment with poor decision making skills.</p> <p>*He had possible schizophrenia (mental disorder often characterized by abnormal social behavior), with a history of alcoholism.</p> <p>*He was independently mobile in a wheelchair.</p> <p>*He did not want to be in the facility and wanted to go home.</p> <p>*No new behaviors identified.</p> <p>*All family members were concerned he would leave the facility.</p>	F 323			

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F 323	<p>Continued From page 23</p> <p>*He had a history of leaving against medical advice from the ER, not waiting for them to discharge him.</p> <p>*He had a Wanderguard (an alarm device that sounded when he came close to an exit door) placed on his wheelchair.</p> <p>Review of resident 1's 1/27/15 care plan standard of care and additional interventions revealed: **Problem:...is classified as a vulnerable adult and has a court appointed guardian. He has instructions to remain at [facility name initials] and participate in skilled therapy until his ankle is fully healed, but he has limited judgement and limited understanding of his need to reside in the facility until his ankle is fully healed and a strong desire to go home." **Goal:...will remain safely in the facility until right ankle is healed." **Approaches: (1) ... has a room on third floor with a Wanderguard on his walker. (2) ... is to remain on 3rd floor for meals and activities until Tuesday February 3rd 2015. (3) On February 3rd 2015 he can resume meals and activities off third floor with staff supervision. (4) Monitor his whereabouts with all opportunities."</p> <p>Review of resident 1's 1/28/15 Elopement Risk Assessment revealed: *He was now ambulating (walking) independently. *He had a history of leaving the facility and not telling the staff. *He had expressed a desire to go home, had packed his belongings, and had stayed near exits. He had wanted to leave, wanted to "get out of here" constantly. *Staff were concerned about him leaving without</p>	F 323			

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F 323	<p>Continued From page 24</p> <p>anyone realizing he was gone.</p> <p>**Incident yesterday 1/27/15 where he went out the back door of [restaurant name] while using the bathroom, was there accompanied by [a social worker from an outside agency] who were there supervising him; police was contacted, he was found inside a bank within walking distance of restaurant name], and they returned to the [facility name]; [facility name] staff were asked by his guardian to come out and talk him into returning to facility; he eventually did, and [facility name] adjusted the plan of care to keeping him on 3rd floor through the next 7 days because of his very high elopement risk."</p> <p>Review of resident 1's care plan standard of care and additional interventions revealed:</p> <p>*On 2/3/15 "He can go down to meals and or activities if staff is available to stay with him at all times. If staff has to leave the area he is in and another staff cannot take over [resident's name] will need to return to 3rd floor. If [resident 1's name] makes any comments about leaving or gives the staff a difficult time about going back up to 3rd floor it may affect later opportunities he may have to go downstairs. His legal guardian states our staff can't give any information to anyone regarding [resident 1's name]. This includes family, friends, or attorneys."</p> <p>*On 2/7/15 "he must stay on the floor at all times-[initials]."</p> <p>Review of resident 1's 2/12/15 Elopement Risk Assessment revealed:</p> <p>*He had cognitive impairment with poor decision making skills.</p> <p>*He had schizophrenia and was a vulnerable adult.</p> <p>*He was ambulating independently.</p>	F 323		

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F 323	<p>Continued From page 25</p> <p>*He had continued to express a desire to go home, packed his belongings, and stayed near exit doors.</p> <p>*There were no new behaviors identified.</p> <p>*Guardian K had expressed elopement concerns.</p> <p>*He was at risk for elopement.</p> <p>*He was to remain on third floor per guardian K's request.</p> <p>Interview on 2/20/15 at 8:25 a.m. with maintenance man G about resident 1 revealed: *Approximately two to three weeks ago social service designee (SSD) F had asked him to place a screw in the window to prevent the window from being opened no more than a small distance. *The screw was a Phillips head screw, he used a drill to put it in, and indicated it had been sticking up approximately a quarter of an inch.</p> <p>Interview and observation on 2/20/15 at 8:40 a.m. with SSD F about resident 1 revealed: *She had wanted him to be safe, and they had used a screw before in a window. She was not aware of the facility Safety policy indicating the modification of windows on third floor. *She had not provided instruction to staff about the screw placed in the window frame. *He had been secluded to the third floor after his return to the facility following an incident on 2/6/15 where he had eloped outside, had become agitated, and had hit staff. He was taken to jail. They were instructed (by whom, not sure) they had to take him back. *He had made it very clear with staff he wanted to leave the facility. *There had been no consistent resident safety checks on him. He had been checked by staff at meal times and during medication administration times.</p>	F 323			

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F 323	<p>Continued From page 26</p> <p>*She agreed he had been a high risk for elopement.</p> <p>*She had not shared her concerns with the social service consultant during weekly meetings or away from the meeting.</p> <p>*She had retrieved the screw that had been placed in the window. It had been found lying in the window tract.</p> <p>She produced the screw; it measured one and one quarter inch in length.</p> <p>Interview on 2/20/15 at 9:35 a.m. with clinical care coordinator H about resident 1 and the Elopement Risk Assessment used by the provider revealed:</p> <p>*When he had first been admitted guardian K had visited frequently, then it had tapered off, and guardian K would keep in contact by phone.</p> <p>*She agreed it had been very important for him to see his dog. Someone from social services had brought his dog in four times in December, three times in January, and one time in February.</p> <p>*She acknowledged and agreed there was nothing to create a score or to quantify with a number or definition and identify who was at risk or not at risk for elopement. The summary allowed for a comment by the assessor. She stated "It is less than a desirable system."</p> <p>Review of facility policy and procedure 6312-50 Safety, section I Safety Precaution Practices, sub section C Facility, number 5 with an effective date of 9/11/07 and a review/revised date of 11/14 revealed:</p> <p>For safety of residents on third floor, windows have been modified so they will only open a small distance.</p> <p>Interview and observation on 2/20/15 at 10:00</p>	F 323		

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F 323	<p>Continued From page 27</p> <p>a.m. with CNA C about resident 1 revealed: *She had been a CNA for twenty years, and she had never experienced such an event as what she had witnessed on 2/13/15. *She had worked on second floor that evening. *Sometime after 8:00 p.m. RN B had asked her if she heard anyone calling for help. She checked the residents on second floor, and no one needed any help. *She could hear someone yelling, she opened the door onto the deck, and it was louder. It was very dark, so she grabbed a flashlight. She and the nurse went down and outside. *He was yelling "get me outta here, get me outta here." *He was sitting at a 45 degree angle kind of slumped with his feet facing toward the street. *We called on the walkie-talkie to the third floor. *He said he jumped out the window; he was going home. *He had a bag with him. She took the jeans out and rolled them up and put them under his head. *We called 911, and when the ambulance came they parked on the street until the police directed the driver into the yard. *We found another bag under the window, and his glasses were in the grass between the building and the tree. *When the area was observed with CNA C, the area was on the west side of the facility in a grassy area where the two sidewalks come together and was several yards from the window and the building.</p> <p>Observation on 2/20/15 from 10:30 a.m. through 10:50 a.m. of the windows in residents' rooms with exception of room 305 and windows in the staff charting area and resident dining area revealed there were screw holes in multiple</p>	F 323		

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F 323	<p>Continued From page 28</p> <p>windows with no screws in them. There were multiple windows with no evidence of a screw hole. The large window at the end of the hall that was over a roof had a Phillips head screw in the window with approximately 1 inch of it exposed. It was positioned approximately 4 to 5 inches from the slider.</p> <p>Interview on 2/20/15 at 11:00 a.m. with CNA I about resident 1 revealed: *She had been a CNA for eighteen years. She had worked a short shift on third floor 6:00 p.m. through 10:00 p.m. on 2/13/15. *She stated "In hindsight there was something different about him that night." *Some time around "7:00ish" he had asked for a Band-Aid; he had cut his finger. She had not been able to get a Band-Aid for him; and had not ask what he had cut his finger on. *He usually went to bed after 9:30 p.m.; that night he went to bed after he had his medications. *She had been providing care to other residents, so "it was all over by the time I was done."</p> <p>Interview on 2/20/15 at 11:10 a.m. with guardian K about resident 1 revealed: *She had gotten an impression on 2/10/15 he was up to something and had called back and communicated that to staff. She asked they not allow him to attend Mass that evening, to keep him on third floor. *She reported his dog had been brought in for visits, but not daily. *He had communicated from the beginning of his stay he did not want to be there. He had been scheduled for a re-evaluation and alternate placement was being reviewed.</p> <p>Interview on 2/20/15 at 11:25 a.m. with business</p>	F 323			

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F 323	Continued From page 29 office person K confirmed there had been communication from the nurse to her on 2/10/15 to notify the DON and administrator about the concerns conveyed by guardian K. Interview on 2/20/15 at 1:00 p.m. with the DON about resident 1 and the events of 2/13/15 revealed: *She had been called; she had contacted the administrator, the SSD, and another member. *She had come in to talk with staff and had checked to see how they were handling the after effects of the situation. She made contact by phone of the staff that had already left that shift. *She thought it was around 10:45 p.m. when she had come in. The SSD came in on the next day to talk to staff and start the investigation. *She had never had this kind of situation to investigate. *RN A and RN B had added some additional notes that were recorded as late entries. *When asked if she had gone into resident 1's room since he had eloped out the window or looked at the outdoor area where he was found on 2/13/15, she replied "No."	F 323			